1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5035

CERTIFICATE OF DEATH

05013

Reg. Dist. No. 94

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown

LENGTH OF STAY (In this place): 33 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) M (Last) Blackwell

4. DATE OF DEATH: (Month) May (Day) 21, (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Dec 5, 1879	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Comm Fisherman	Fishing	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Theodore Blackwell	Elizabeth Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		Joseph R Lamb North East, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

3327 IMMEDIATE CAUSE (A) Rt. Cerebral Thrombosis with left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis — 10 yrs.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	—	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
— M.		—

22. I hereby certify that I attended the deceased from 17 March, 1956, to 21 May, 1956, that I last saw the deceased alive on 8 May, 1956, and that death occurred at 8:35 M. from the causes and on the date stated above.

SIGNATURE	M.D. ADDRESS (Street, city, town, state)	DATE SIGNED
Klaus H. Kircher	North East, Md	21 May '56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 24 1956	Charlestown	Charlestown, Cecil, Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5-24-56	Sarah C. Rothamel	Joseph R Lamb North East, Maryland

RECEIVED
MAY 29 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05014

5036

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY Cecil MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton-Rt 1 | LENGTH OF STAY (in this place) 16 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Cecil
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Near Elkton
STREET ADDRESS (If rural give location) Elkton R.D. 1.

3. NAME OF DECEASED: (Type or Print) (First) Mabel (Middle) Rebecca (Last) Jordan Boozman
4. DATE OF DEATH: (Month) May (Day) 30 (Year) 1956
5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed | 8. DATE OF BIRTH: Mar 17th 1891 | 9. AGE last birthday: 65 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none | 10B. KIND OF BUSINESS OR INDUSTRY: At Home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Jordan | 14. MOTHER'S MAIDEN NAME: Mary Alice Irwin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS: Henry G. Leak, Son Elkton R.D.1 Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Dec 1-55

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Total Paralysis — May 29-56

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension & Arteriosclerosis

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1st 1955 to May 30th 1956 that I last saw the deceased alive on May 29 1956, and that death occurred at 11.45 M, from the causes and on the date stated above.
SIGNATURE H. M. Leak M.D. ADDRESS Elkton Maryland DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial. | DATE THEREOF June. 2/56 | NAME OF CEMETERY OR CREMATORY Elkton | LOCATION (City, town, or county) (State) Elkton, Md

DATE REC'D BY LOCAL REGISTRAR June 2 | REGISTRAR'S SIGNATURE H R Frazer | 24. FUNERAL DIRECTOR B Henry Tipton | ADDRESS Elkton, Md.

VS. A15—10-

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05015

5017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: visit
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N.J. — b. COUNTY: Essex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Orange
d. STREET ADDRESS: 40 Sussex
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Baynard — Last: Brady

4. DATE OF DEATH: Month: 5 — Day: 30 — Year: 19 56

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-8-1905

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Any kind of work

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas B. Brady

14. MOTHER'S MAIDEN NAME: No Information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 155-14-756[illegible]

17. INFORMANT — Address: Sylvania Brady, 40 Sussex Ave E.Orange N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 5-30-56

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-2-56

22c. NAME OF CEMETERY OR CREMATORY: Bohemia Manor Cem.

22d. LOCATION (City, town, or county) (State): Bohemia Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edw R Bell — ADDRESS: Wilm., Dela.

24a. REC'D BY REGISTRAR DATE: 6/1/56

24b. REGISTRAR'S SIGNATURE: H R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05016 92

Reg. Dist. No. 201

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D O A Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton 14 x 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle ROBERT Last BRICE

4. DATE OF DEATH: Month 5 Day 18 Year 1956

5. SEX: M. — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 7-14-1931 — 9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elect Helper — 10b. KIND OF BUSINESS OR INDUSTRY: Electrical — 11. BIRTHPLACE (State or foreign country): Betterton Md. — 12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Harry Samuel Brice — 14. MOTHER'S MAIDEN NAME: Anna Bell Story

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes. — If yes, give war or dates of service): Korean — 16. SOCIAL SECURITY NO.: 220-28-4119 — 17. INFORMANT: Mrs. H L Owens — Address: Betterton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
916.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Oil Tank exploded at Kentoil Co yard.
20c. TIME OF INJURY Hour: 8 o. m. p. m. — Month, Day, Year: 5-18 1956
20d. INJURY OCCURRED White at work ☒ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Kentoil Co
20f. (City or town): Galena — (County): Kent — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R C Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-18-56

EXAMINER'S NAME (Type): R C Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried — 22b. DATE THEREOF: 5-18-56 — 22c. NAME OF CEMETERY OR CREMATORY: STILL POND, CEMTY — 22d. LOCATION (City, town, or county): STILL POND, — (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: Still Pond, Md. — 24a. REC'D BY REGISTRAR DATE: 5/18/56 — 24b. REGISTRAR'S SIGNATURE: E Raymond Price J. Rodney Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay [illegible] please execute this certificate, [illegible] the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. [illegible] should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65017

5937

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital
d. STREET ADDRESS: Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle H. Last DAUGHERTY, JR.

4. DATE OF DEATH: Month May Day 1 Year 19 56

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 12-3-07
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H. Daugherty Sr.
14. MOTHER'S MAIDEN NAME: Mary Somers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 2151 26 549
17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hepatic coma	48 hrs.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Portal cirrhosis upper gastro-intestinal	1 year
DUE TO (c)	Hemorrhage due to bleeding esophageal varices	3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month VA Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 28, 19 56, to May 1, 19 56, that I last saw the deceased alive on [illegible], and that death occurred at 6:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. M. Harris M.D. ADDRESS (Street, city or town, state): VAH, Perry Point, Md. DATE SIGNED: 5-1-56

PHYSICIAN'S NAME (Type): WM. M. HARRIS — Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5-1-56
22c. NAME OF CEMETERY OR CREMATORY: Unknown
22d. LOCATION (City, town, or county) (State): Crisfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Bradshaw & Sons Funeral Home, Crisfield, Md.
24a. REC'D BY REGISTRAR DATE 5-1-56
24b. REGISTRAR'S SIGNATURE: Jane E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: Neither this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VE A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5019 — 05018 — Reg. Dist. No. 47

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: All Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 393 W. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton,
d. STREET ADDRESS: 393 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie May — Middle: — Last: Dick
4. DATE OF DEATH: Month: 5 — Day: 12 — Year: 1956

5. SEX: F.
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-7-1871
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Elkton, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Foracre
14. MOTHER'S MAIDEN NAME: No information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Melrose Short, 393W.Main St. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute CoronaryThrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-12-56
EXAMINER'S NAME (Type): R.C.Dodson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-15-56
22c. NAME OF CEMETERY OR CREMATORY: New Catholic
22d. LOCATION (City, town, or county) (State): Elkton, Md
23. FUNERAL DIRECTOR'S SIGNATURE: Thomas Tippin — ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: 5/15/56
24b. REGISTRAR'S SIGNATURE: H R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain. Complete certificate, including the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5938

CERTIFICATE OF DEATH

05019

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville Rural
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Mary — Last: Downey

4. DATE OF DEATH: Month: May — Day: 13 — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 14, 1887

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Lee

14. MOTHER'S MAIDEN NAME: Emma Brousius

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Maryland
Mrs. Lewis A. Wright, Perryville, R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): Arteriosclerosis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Diabetes — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I attended the deceased from June, 1955, to May 13, 1956, that I last saw the deceased alive on May 12, 1956, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Box 1 Perryville, Md.

DATE SIGNED: 5-14-56

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-16-56

22c. NAME OF CEMETERY OR CREMATORY: Sharp's Cemetery

22d. LOCATION (City, town, or county) (State): Fair Hill, Cecil Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son

ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: 5-15-56

24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5020 05020

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please explain. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS: West Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Neeper — Middle: James — Last: Edwards
4. DATE OF DEATH: Month: 5 — Day: 21 — Year: 1956
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 2 1872
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lab.
10b. KIND OF BUSINESS OR INDUSTRY: Butcher shop
11. BIRTHPLACE (State or foreign country): Lancaster Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Edwards
14. MOTHER'S MAIDEN NAME: Lavinia Coulson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Helen Plummer, Rising Sun. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemmorrhage
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-22-56

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-25-56
22c. NAME OF CEMETERY OR CREMATORY: Brookvein Cemetery
22d. LOCATION (City, town, or county) (State): Rising Sun Cecil Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J.E. Tyson — ADDRESS: Rising Sun. Md.
24a. REC'D BY REGISTRAR DATE: May 23-56
24b. REGISTRAR'S SIGNATURE: Lynn Wilmington

VS. AT5ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5940 — 05021 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Port Deposit
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Granite Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: Granite Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Betty — Middle: Jean — Last: Fields
4. DATE OF DEATH: Month: 5 — Day: 30 — Year: 19 56

5. SEX: F.
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-9-56
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 3 — Days: 21 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Havre De. Grace. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Fields Jr.
14. MOTHER'S MAIDEN NAME: Pear Hicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Pear Hicks. Granite Ave. Port Deposit. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration of food.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Vomited and aspirated the food.
20c. TIME OF INJURY: Hour: 11 o. m. p. m. — Month, Day, Year: 5-29-56 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Port Deposit (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-30-56
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 1 1956
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Sm.
22d. LOCATION (City, town, or county) (State): Pen Mar Sprout Md.

23. FUNERAL DIRECTOR'S SIGNATURE: L.E. Tyson. — ADDRESS: Rising Sun. Md.
24a. REC'D BY REGISTRAR DATE: June 1-56
24b. REGISTRAR'S SIGNATURE: Emmy Worthington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05022

5941

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 15 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d STREET ADDRESS: 2227 W. Hobart Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Henry — Middle: (NMI) — Last: Greenberg

4. DATE OF DEATH: Month: May — Day: 12, — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-22-94

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Roumania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Greenberg

14. MOTHER'S MAIDEN NAME: Sarah Goldenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 6 - 7 Days
DUE TO Arteriosclerotic heart disease, with
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) myocardial fibrosis — Unk.
DUE TO
(c) Arteriosclerosis, general, severe — Unk.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 27, 19 56, to May 12, 19 56 ~~that I last saw the deceased alive on~~, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Grasberger M.D. — ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md. — DATE SIGNED: 5-13-56

PHYSICIAN'S NAME (Type): J. C. GRASBERGER, M.D., Acting Dir., Professional Services, VAH, Perry Point, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 5-13-56

22c. NAME OF CEMETERY OR CREMATORY: Unknown

22d. LOCATION (City, town, or county) (State): Philadelphia, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Farrington Son — ADDRESS:

24a. REC'D BY REGISTRAR DATE: 5-13-56

24b. REGISTRAR'S SIGNATURE: Irene E. Keough

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by hospital or attending physician.
TO FUNERAL DIRECTOR: Under this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05023
Reg. Dist. No.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt exists as to the necessity for an autopsy, please execute the certificate, noting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND — 5442
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun Rural
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Dennis — Last: Hamilton

4. DATE OF DEATH: Month: 5 — Day: 12 — Year: 1956

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-27-1911

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Chryler Plant

11. BIRTHPLACE (State or foreign country): Beaver, Ken.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sie Hamilton

14. MOTHER'S MAIDEN NAME: Dolly Pope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 200-0307278

17. INFORMANT — Address: Stella Hamilton, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-12-56

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-15-56

22c. NAME OF CEMETERY OR CREMATORY: New Bridge Bapt. Cem.

22d. LOCATION (City, town, or county) (State): Colora, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lemuel E. McMullen — ADDRESS: Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE: May 14 56

24b. REGISTRAR'S SIGNATURE: Lou Huntington

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05024 5043

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, Rural
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Woodrow — Middle: Reo — Last: Hardiman

4. DATE OF DEATH: Month: 5 — Day: 12 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-27-1919

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): Allegany, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Carl Hardiman

14. MOTHER'S MAIDEN NAME: Mary Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.2

16. SOCIAL SECURITY NO.: 225-14-8010

17. INFORMANT Address: Catherine Hardiman, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed head and fracture of right clavicle

DUE TO (b): abrasions of legs and hand.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Car turned over and landed on his head.

20c. TIME OF INJURY: Hour: 9.45 a. m. p. m. — Month, Day, Year: 5 12 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Scotts Creek Road — **20f.** (City or town): Fair Hill — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-12-56

EXAMINER'S NAME (Type): R.C. Dodson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: 5-15-56 — **22c. NAME OF CEMETERY OR CREMATORY**: Union Cemetery — **22d. LOCATION** (City, town, or county) (State): Elkton Rural, Md. 5-15-56

23. FUNERAL DIRECTOR'S SIGNATURE: Henry Triplett — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: 5/15/56 — **24b. REGISTRAR'S SIGNATURE**: H H Fraser

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05025

Reg. Dist. No. 97

Item 18 Film 3298 5 [illegible]

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND — 5044
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manor Heights, Port Deposit, Md.
d. STREET ADDRESS: 207 C1 Laffey Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH — Middle: (N) — Last: HOLMES
4. DATE OF DEATH: Month: MAY — Day: 16 — Year: 19 56
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-24-56
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 — Days: 22
IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Bainbridge, Md.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: George Anderson HOLMES
14. MOTHER'S MAIDEN NAME: Mildred Anderson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: ---
17. INFORMANT — Address: Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UNDETERMINED — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): (Could not make diagnosis from autopsy)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 795.5
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: R. C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-16-56
EXAMINER'S NAME (Type): R. C. DODSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-17-56
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson for — ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: 5-16-56
24b. REGISTRAR'S SIGNATURE: Dorothy B. Bramble

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05026

5245

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BS A15 (4)
ISM 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland — b COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md. — c. LENGTH OF STAY IN 1b: D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital	d STREET ADDRESS: 1145 Avenue B — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JAMES	QUINTER	HOLSOPPLE	May	10	1956

5 SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White		July 26,1900	55 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Psychologist	Psychology	Parkerford, Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank F. Holsopple	Grace Quinter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
Yes	WW I - WW II		Mrs. Nell Scott Holsopple, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

4.20.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1956, to May 10, 1956, that I last saw the deceased alive on May 9, 1956, and that death occurred at 11:45PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. P. Brannon M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 5-11-56

PHYSICIAN'S NAME (Type): E. P. BRANNON — Manager

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	5-14-56	Greenmount Crematory	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
Pennington & Son, Havre de Grace, Md.	May 11 1956	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05027

5920 # CERTIFICATE OF DEATH

Reg. Dist. No. ...

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH

COUNTY: CECIL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON

LENGTH OF STAY (in this place): 12 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: UNION HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md — COUNTY: CECIL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHILOS

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) (Last) Kinder

4. DATE OF DEATH (Month) May (Day) 12 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min.
FEMALE	WHITE	W, D or W	4-13-1880	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	VIRGINIA	U S A

13. FATHER'S NAME: WINTON HESTER

14. MOTHER'S MAIDEN NAME: MARY HANKLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	None.	Robert C White Childs Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSE(S) DUE TO (B): Myocardial infarction — 5 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Bronchial - Colitis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 13, 19 55, to May 12, 19 56, that I last saw the deceased alive on May 12, 19 56, and that death occurred at 4:54 P.M., from the causes and on the date stated above.

SIGNATURE: Dalford Sprecher M.D. — ADDRESS (Street, city, town, state): Elkton Md — DATE SIGNED: May 14, 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-14-56	Union	Elkton Rd Cecil Co Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5/14/56	J R Bruger	Joseph R Grant Inc Elkton Md

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05028

5921

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b 38 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) lol Caroline

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
d. STREET ADDRESS 101Caroline
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Catherine Middle Last Kline

4. DATE OF DEATH Month 5 Day 24 Year 19 56

5. SEX F.

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 12-4- 1872

9. AGE (In years last birthday) 83 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY House work

11. BIRTHPLACE (State or foreign country) Philadelphia. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Wheeler

14. MOTHER'S MAIDEN NAME No information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Vernon Kline &Mrs. Address James Moore ElktMdM

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) R.C.Dodson

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 5-25-56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF May 26/56

22c. NAME OF CEMETERY OR CREMATORY North East Meth Cemt.

22d. LOCATION (City, town, or county) North East (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Elkton, Md

24a. REC'D BY REGISTRAR DATE 5/28/56

24b. REGISTRAR'S SIGNATURE H R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05029

Reg. Dist. No. 92

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Chesapeake City
d. STREET ADDRESS Biddle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hosp. D C C.

3. NAME OF DECEASED (Type or print) First Richard Middle Lockwood Last LOLLER

4. DATE OF DEATH Month 5 Day 18 Year 1956

5. SEX M.

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 10-16-1918

9. AGE (In years last birthday) 37 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic

10b. KIND OF BUSINESS OR INDUSTRY Check Cole

11. BIRTHPLACE (State or foreign country) Danville Ind.

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME James D Loller

14. MOTHER'S MAIDEN NAME Emma E Craig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 2.

16. SOCIAL SECURITY NO. 217-22-3353

17. INFORMANT Mrs Richard L Loller Address Chesapeake City Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fighting Fire at Rent Oil Co. Galena, Md.

20c. TIME OF INJURY Hour 0 o. m. p. m. Month, Day, Year 5-16-56

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rent Oil Co

20f. (City or town) Galena (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R C Dodson M.D.

EXAMINER'S NAME (Type) R C Dodson, M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 5-18-56.

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal

22b. DATE THEREOF 5-18-56

22c. NAME OF CEMETERY OR CREMATORY Johnstown-Cem.

22d. LOCATION (City, town, or county) (State) Rural Earleville Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fillow ADDRESS Millington Md.

24a. REC'D BY REGISTRAR DATE 5/24/56

24b. REGISTRAR'S SIGNATURE F R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05030

5023 # CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural) #1

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) E (Last) Mearns

4. DATE OF DEATH (Month) May (Day) 10 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	Married	Sept. 5 1885	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm owner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Miller Mearns

14. MOTHER'S MAIDEN NAME Hannah Elizabeth Crothers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-18-7314

17. INFORMANT & ADDRESS Mrs James F Mearns

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Urinary Tract Infection — INTERVAL BETWEEN ONSET AND DEATH April 21-56

ANTECEDENT CAUSE(S) DUE TO (B) Benign prostatic hypertrophy

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis, generalized.

19a. DATE OF OPERATION April 10, 1956

19b. MAJOR FINDINGS OF OPERATION Benign prostatic hypertrophy

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 5, 1956, to May 10, 1956, that I last saw the deceased alive on May 9, 1956, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE and M.D. Mitford Strahan M.D. — ADDRESS (Street, city, town, state) Elkton, Md. — DATE SIGNED May 10, 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 13-1956	North East Methodist Cem	North East Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5/14/56	J R Frazer	Joseph K. Grant North East, Md.


BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5046

Reg. Dist. No. 05031

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,
c. LENGTH OF STAY IN 1b: 5yrs4mos.14days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS: 503 Ethan Allen Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EARL — Middle M. — Last MEINERS

4. DATE OF DEATH: Month May — Day 27 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 28, 1896

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printing Specialist

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy Dept.

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN H. MEINERS

14. MOTHER'S MAIDEN NAME: REBECCA SCHMERTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I

16. SOCIAL SECURITY NO.: Unkown

17. INFORMANT — Address: Hospital Records, VAH., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Aortic valve calcification of, and aortic insufficiency — unknown
DUE TO
(c) Arteriosclerotic coronary heart disease, severe — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, general, severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

VA

21. I certify that I attended the deceased from Jan. 13, 19 51 to May 27, 19 56 and that death occurred at 6:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W Oppler M.D. — ADDRESS (Street, city or town, state): Perry Point, Md. — DATE SIGNED: 5-28-56

PHYSICIAN'S NAME (Type): W.Oppler, M.D., Director, Professional Services, VAH., Perry Point, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 5-28-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: PENNINGTON & SON, — ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE 5-29-56
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

05032

5947 2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Cecil — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Earleville — LENGTH OF STAY (In this place) 24 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westview Shores

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania — COUNTY Schuylkill
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Schuylkill Haven
STREET ADDRESS (If rural give location) Hill Farm

3. NAME OF DECEASED (Type or Print): (First) Wilson (Middle) (Last) Minnich
4. DATE OF DEATH: (Month) May (Day) 5 (Year) 19-56
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 1874
9. AGE last birthday: 82 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lebanon Co. Pa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jacob Minnich
14. MOTHER'S MAIDEN NAME: Matilda Bahr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Stanley Schwartz

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 11 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cerebral Arteriosclerosis — years
(c) Generalized Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 19 56, to May 5, 19 56, that I last saw the deceased alive on May 5, 19 56, and that death occurred at 9:55 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Wallace Thompson MD — Ceciltn Md — 5 May 56

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 9/56 — NAME OF CEMETERY OR CREMATORY: Kentwood Cem't — LOCATION (City, town, or county) (State): Pine Grove R.D. Pa

DATE REC'D BY LOCAL REG.: May 5 — REGISTRAR'S SIGNATURE: F R Frazer — 24. FUNERAL DIRECTOR: Anthony Lippini — ADDRESS: Elkton, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film [illegible]

5024

CERTIFICATE OF DEATH

05033 92
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 317 Curtis Ave.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 317 Curtis Ave.
• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: E. — Last: Moore

4. DATE OF DEATH: Month: May — Day: 2 — Year: 1956

5. SEX: M

6. COLOR OR RACE: Wh

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 7, 1883

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: General Labor

11. BIRTHPLACE (State or foreign country): Elkton, Md.

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Moore

14. MOTHER'S MAIDEN NAME: Annie Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 213-03-9060

17. INFORMANT: Arthur R. Moore — 322 North St. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Both Lungs — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
163X
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 56 to May 2 19 56, that I last saw the deceased alive on May 1 19 56, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

PHYSICIAN'S NAME (Type): [illegible] — ADDRESS (Street, city or town, state): [illegible] Elkton Md — DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-5-1956

22c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception

22d. LOCATION (City, town, or county) (State): R. D. Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Elkton Md

24a. REC'D BY REGISTRAR DATE: 5/5/56

24b. REGISTRAR'S SIGNATURE: H H Frazier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 050342

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elkton U/I

2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission)
a. STATE Pa. b. COUNTY Lancaster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quarryville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Roger Middle: R. Last: Moore
4. DATE OF DEATH Month: 5 Day: 3 Year: 1956

5. SEX M
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-5-1956
9. AGE (In years last birthday) yrs. 7 mos. 28 days
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lancaster Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James E. Moore
14. MOTHER'S MAIDEN NAME Freda Betty Kauffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT James E. Moore Address Quarryville Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchial — INTERVAL BETWEEN ONSET AND DEATH
U49.X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Pneumonitis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R C Dudson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-3-56
EXAMINER'S NAME (Type) R C Dudson

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Burial May 6 1956
22c. NAME OF CEMETERY OR CREMATORY Oxford Pa.
22d. LOCATION (City, town, or county) (State) Oxford Chester Co Pa

23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed ADDRESS Rising Sun
24a. REC'D BY REGISTRAR DATE May 5-56
24b. REGISTRAR'S SIGNATURE L M Worthington By F. Rodney Lacy

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5926

CERTIFICATE OF DEATH

05035 Reg. Dist. No. 12

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 65 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 129 Moffitt St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First J. Middle Edwin Last Naylor
4. DATE OF DEATH: Month May Day 2 Year 19 56
5. SEX: M
6. COLOR OR RACE: Wh
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 17, 1884
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Forman
10b. KIND OF BUSINESS OR INDUSTRY: Textile Mills
11. BIRTHPLACE (State or foreign country): Blackbird, Del.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: William J. Naylor
14. MOTHER'S MAIDEN NAME: Saddie F. Wallace
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-07-5832
17. INFORMANT: Mrs. Elizabeth M. Naylor Address 129 Moffitt St. Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of the prostate — INTERVAL BETWEEN ONSET AND DEATH: 1 year
100X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of the prostate
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 19 56, to May 2, 19 56, that I last saw the deceased alive on May 2, 19 56, and that death occurred at 2:40 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 216 E. Main St. Elkton, Md.
DATE SIGNED: 5-3-56
PHYSICIAN'S NAME (Type): J. Ralph Hamilton, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-6-1956
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memo. Pk.
22d LOCATION (City, town, or county) (State): R. D. Elkton Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS
24a. REC'D BY REGISTRAR DATE: 5/5/56
24b. REGISTRAR'S SIGNATURE: F R Brazen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, FilmCly) 5-11-56 et

5927

CERTIFICATE OF DEATH

05036 52

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 18 hours.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena
d. STREET ADDRESS: Starkey Farm
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Sofia; Middle; Last Olyznyk
4. DATE OF DEATH: Month May; Day 1; Year 1956
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: D... ...-25-[illegible]
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? D.P.

13. FATHER'S NAME: Czian
14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 21[illegible]
17. INFORMANT: Address: Stephen Olyznyk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio-Vasular Disease 3 years.
DUE TO (c): Chronic glomerulo-nephritis.
402.x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Hemorrhage and Hypertensive encephalopathy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m.; Month; Day; Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 56, to May, 19 56, that I last saw the deceased alive on May 1, 19 56, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenchain M.D. ADDRESS (Street, city or town, state): Elkton, Md DATE SIGNED: 1 May 56.

PHYSICIAN'S NAME (Type): Wallace Obenchain, M. D. Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: May 3, 1956
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 259 E. Main St

24a. REC'D BY REGISTRAR DATE: 5/5/56
24b. REGISTRAR'S SIGNATURE: J R Frazer

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5928

CERTIFICATE OF DEATH

05037

Reg. Dist. No. 92

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

LENGTH OF STAY (In this place): 1 day

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) J. (Last) Peterman

4. DATE OF DEATH (Month) May (Day) 27 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	June 21, 1876	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bridge Carpenter	R.R. Ret.	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Allen Peterman	Elizabeth Spence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	717-09-2659	Ida Peterman North East, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Rt. Cerebral Hemorrhage with left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 42 hrs.

ANTECEDENT CAUSE(S) DUE TO (B): Generalized Arteriosclerosis — 10 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C): —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
— M.		—

22. I hereby certify that I attended the deceased from 15 March, 1956, to 27 May, 1956, that I last saw the deceased alive on 26 May, 1956, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

SIGNATURE: Klaus H. Hueber M.D. ADDRESS (Street, city, town, state): North East Rd DATE SIGNED: 28 May '56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 31, 56	Cherry Hill Methodist	Elkton Rd Cecil, Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
5/31/56	E R Frazer	Joseph R. Grant	North East, Md

1956

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5948

CERTIFICATE OF DEATH

~~05035~~ 05038

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Pennsylvania b. COUNTY:
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point	c. LENGTH OF STAY IN 1b: 9 mo. 1 day
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Grove
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital	d. STREET ADDRESS: R.D. 1 — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOSEPH	B.	PORTER	May	9	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
Male	White		11-7-20	35 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Hand	Farm	West Grove, Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clarence Porter	Rhoda Shivery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW II	161-24-2256	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia due to undetermined cause — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Brain tumor - Recurrent astrocytoma, left — unknown

DUE TO

(c) frontal and temporal regions. (Post-operative)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
VA			

21. I certify that I attended the deceased from August 8, 1955, to May 9, 1956 [illegible] and that death occurred at 9:45 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 5-9-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	5-9-56	New London	New London, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Foulk Funeral Home, West Grove, Pa.	May 9 1956	Irene Daugherty

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5029 **CERTIFICATE OF DEATH** 05039

Reg. Dist. No. 9r

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton

LENGTH OF STAY (In this place) 5 Hours

HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton

STREET ADDRESS (If rural give location) P.O Box 49

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) (Last) SIMMONS

4. DATE OF DEATH (Month) May (Day) 22 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min
M	W	Single	5/21/56	Yrs.			5	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
—	—	Elkton Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Riley	Barbara Ann Simmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	— —	

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

☐ IMMEDIATE CAUSE (A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 5 hours

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Anoxia due to Lt Blood loss before delivery

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Marginal Placenta Previa

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 May, 1956, to 22 May, 1956, that I last saw the deceased alive on 21 May, 1956, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE George J. Kneas M.D. ADDRESS (Street, city, town, state) Elkton Md DATE SIGNED 5/22/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/24/1956	Elkton Cemetery	Elkton, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5/24/56	H H Fragen	H Walter Du Boos, W.

Spence

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05040

5030 **CERTIFICATE OF DEATH**

Reg. Dist. No. 92

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: CECIL — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON

LENGTH OF STAY (in this place): 36 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: UNION Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md — COUNTY: CECIL

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON

STREET ADDRESS (If rural give location): R.D Providence

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) S. (Last) Spence S. C.

4. DATE OF DEATH (Month) May (Day) 12 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE	MARRIED	Aug 11, 1893	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	MARYLAND	U.S.A

13. FATHER'S NAME: WM P KITE

14. MOTHER'S MAIDEN NAME: ELIZABETH JORDAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Robert Stanley Spence Elkton RFD Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Carcinoma of

ANTECEDENT CAUSE(S) DUE TO (B): Cervix Uteri

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

INTERVAL BETWEEN ONSET AND DEATH: 1954

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Oct. 1954	Carcinoma of cervix uteri.	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan ....., 19 56, to May 12, 1956, that I last saw the deceased alive on May 12, 1956, and that death occurred at 8:55 P. M, from the causes and on the date stated above.

SIGNATURE: Clifford Spencer M.D. ADDRESS (Street, city, town, state): Elkton, Md DATE SIGNED: May 14, 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-15-56	Sharps	Elkton R.F.D Cecil Co, Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5/14/56	J.R. Frazer	Jasper A. Grantham Elkton Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5049 **CERTIFICATE OF DEATH** Reg. Dist. No. 05041

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge, Md.
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TINA Middle MARCHEL Last STEWART

4. DATE OF DEATH: Month May Day 11 Year 1956

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-7-56
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days 4
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald Edward STEWART
14. MOTHER'S MAIDEN NAME: Eleanor Cordelia CLARK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Navy Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): INTESTINAL ATRESIONS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 756.2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-7, 1956, to 5-11, 1956, that I last saw the deceased alive on 5-11, 1956, and that death occurred at 0958 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE for C. Engel M.D. U. S. Naval Hospital, Bainbridge, Md. 5/11
PHYSICIAN'S NAME (Type) G. J. O'DONNELL, LT MC USNR, U. S. NAVAL HOSPITAL, BAINBRIDGE, MD. 5/11/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-11-56
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Cemetery
22d. LOCATION (City, town, or county) (State): Cecil Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee A Patterson for Perryville, Md
24a. REC'D BY REGISTRAR DATE: 5/11/56
24b. REGISTRAR'S SIGNATURE: Dorothy L. Trimble

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5050

CERTIFICATE OF DEATH

05042

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Pennsylvania — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md. — c. LENGTH OF STAY IN 1b: 9 mo. 15 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital	d. STREET ADDRESS: 7943 Fayette Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ERNEST	B.	SYKES	May	16	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White		4-6-97	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanical Engineer	Power Engine Design	Massachusetts	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ernest Sykes	Sarah Beaumont

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes — WW I & WW II	160-09-4232	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia, bilateral	10-12 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Peritonitis, localized & diffuse, due to	10 days
DUE TO (c)	ruptured peptic ulcer Arteriosclerosis, general, severe	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
VA	19			

21. I certify that ☒attended the deceased from August 1, 1955, to May 16, 1956 [illegible] and that death occurred at 12:05a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Oppler M.D. — ADDRESS (Street, city or town, state): V.A.Hospital, Perry Point, Md. — DATE SIGNED: 5-16-56

PHYSICIAN'S NAME (Type): W. OPPLER — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	5-16-56	Beverly National	Beverly, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Harold B. Mulligan, 1119 W. Lehigh Ave. Phila. Pa.	May 16, 1956	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5931

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05043 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN (b) all life

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Bay~~ Chesapeake City
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital

3. NAME OF DECEASED (Type or print) First Augustus Middle Last TATMAN

4. DATE OF DEATH Month 5 Day 11 Year 1956

5. SEX M. | 6. COLOR OR RACE White | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH June 2 1894 | 9. AGE (In years last birthday) 61 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | 10b. KIND OF BUSINESS OR INDUSTRY Boats | 11. BIRTHPLACE (State or foreign country) Chesapeake City Md. USA | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME no information | 14. MOTHER'S MAIDEN NAME Cora Tatman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Mrs Felicia Tatman Chesapeake City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☑, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R L Dodson M.D. | CHIEF MEDICAL EXAMINER ☐ | ASSISTANT MEDICAL EXAMINER ☐ | DEPUTY MEDICAL EXAMINER ☒ | DATE SIGNED 5-11-56

EXAMINER'S NAME (Type) R C Dodson MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/15/56 | 22c. NAME OF CEMETERY OR CREMATORY St Rose's Catholic | 22d. LOCATION (City, town, or county) (State) Chesapeake City, Md

23. FUNERAL DIRECTOR'S SIGNATURE Henry Tippin ADDRESS Elkton, Md. | 24a. REC'D BY REGISTRAR DATE 5/15/56 | 24b. REGISTRAR'S SIGNATURE F R Bridges

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. [illegible] should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5951 **CERTIFICATE OF DEATH** 65044

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ellen — Middle Adair — Last Price Taylor

4. DATE OF DEATH: Month May — Day 18 — Year 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 29, 1880

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jeremiah Cosden Price

14. MOTHER'S MAIDEN NAME: Arabelle Veach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Ernest Taylor, Perryville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Liver — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 55 1955 to May 17 1956 that I last saw the deceased alive on May 17 1956, and that death occurred at 4:30 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C. I. Benson M.D.
ADDRESS (Street, city or town, state): Port Deposit, Md
DATE SIGNED: 5-19-56
PHYSICIAN'S NAME (Type): C. I. BENSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 20, 1956
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit Rural, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Son
ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: 5-17-56
24b. REGISTRAR'S SIGNATURE: Irma E. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5232 **CERTIFICATE OF DEATH** 105045 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rebecca — Middle — Last ETHEL R TAYLOR
4. DATE OF DEATH: Month 5 — Day 6 — Year 1956

5 SEX: F — 6. COLOR OR RACE: W. — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 1902 — 9 AGE (In years last birthday): 54 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Home — 11. BIRTHPLACE (State or foreign country): Honey Brook, Penna — 12. CITIZEN OF WHAT COUNTRY: U.S.

13 FATHER'S NAME: Willard Mc Connell — 14. MOTHER'S MAIDEN NAME: May White

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT: Mr. Henry Taylor — R. D. 1 Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Progressive secondary shock — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Acute gastroenteritis — 18 hours
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year —, 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-25, 1956, to 5-5, 1956, that I last saw the deceased alive on 5-6, 1956, and that death occurred at 5:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter Stavrakis, M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 5-6-56

PHYSICIAN'S NAME (Type): PETER STAVRAKIS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 9, 1956
22c. NAME OF CEMETERY OR CREMATORY: Philadelphia Memorial Pk.
22d. LOCATION (City, town, or county) (State): Chester Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: William F. Jones — ADDRESS: Claymont, Del.
24a. REC'D BY REGISTRAR DATE: 5/8/56
24b. REGISTRAR'S SIGNATURE: J R Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05046

5052

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED
COUNTY Cecil — MARYLAND	STATE Maryland COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perryville — LENGTH OF STAY (In this place) 56 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perryville
HOSPITAL OR INSTITUTION OR STREET ADDRESS Aikin Ave.	STREET ADDRESS (If rural give location) Aikin Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frank	Hopper	Walker	May	1	1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	June 10, 1878	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brakeman, Retired	Rail Road	Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Crawford Walker	Margaret Sutor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		Eva B. Walker, Perryville, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: IMMEDIATE CAUSE (A)	Pulmonary Oedema	1 day.
ANTECEDENT CAUSE(S) DUE TO (B)	Chronic Myocarditis	2 years.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Hemiplegia Left side	1 year.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Arteriosclerosis	10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to May 1, 1956, that I last saw the deceased alive on May 1, 1956, and that death occurred at 10 A.M. from the causes and on the date stated above.

SIGNATURE	M.D.	ADDRESS (Street, city, town, state)	DATE SIGNED
Frank Wolbert MD		Havre de Grace Md -	May 2-1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-4-1956	Principio	Principio Furnace, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
5-2-56	Irene E. Davy Lesty	Lee A. Patterson & Son, Perryville, Md.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5033

05047

Reg. Dist. No. 9

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LESTER Middle JACK Last WHITEMAN
4. DATE OF DEATH Month 5 Day 6 Year 1956
5. SEX M.
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-24-1903
9. AGE (In years last birthday) 53 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher
10b. KIND OF BUSINESS OR INDUSTRY H School Teacher
11. BIRTHPLACE (State or foreign country) Johnston W. Va.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Mortimer Whiteman
14. MOTHER'S MAIDEN NAME Betty Scrivner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) WW 2
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. Ruth Whiteman, Elkton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE R C Dodson M.D.
EXAMINER'S NAME (Type) R C Dodson, M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-7-56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5-9-56 5-10-56
22c. NAME OF CEMETERY OR CREMATORY Masonic
22d. LOCATION (City, town, or county) (State) Johnston, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE H Henry Pippin
ADDRESS Elkton, Md.
24a. REC'D BY REGISTRAR DATE 5/10/56
24b. REGISTRAR'S SIGNATURE H R Frazer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the cause of death should be entered on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05048

5934

CERTIFICATE OF DEATH

Reg. Dist. No. 92

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Md

LENGTH OF STAY (In this place) 4 Weeks

HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton

STREET ADDRESS (If rural give location) 107 Osage St.

3. NAME OF DECEASED (Type or Print) (First) Helen (Middle) Wells (Last) Wright

4. DATE OF DEATH (Month) May (Day) 31, (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Aug 16, 1883	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	School	Elkton, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin M. Wells	Mary A. Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No			Norman Wright, Elkton, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

570.5 IMMEDIATE CAUSE (A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Recurrent Intestinal Obstruction

DUE TO (C) Intestinal Obstruction — adhesions

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
May 15 1956	Intestinal Obstruction	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1956, to May 31, 1956, that I last saw the deceased alive on May 31, 1956 and that death occurred at 1:1 P.M. from the causes and on the date stated above.

SIGNATURE J. Arthur Cornwell M.D. **ADDRESS** (Street, city, town, state) North East Maryland **DATE SIGNED** June 1, 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6/3/56	Elkton Cem.	Elkton Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
6/3/56	J R Frazer	H. Walter du Bois, Jr.	Elkton, Md.